Residential Transitions Project
Phase One

Final Report

Submitted to
Casey Family Programs
by
Child Welfare League of America
April, 2008

I. Introduction

The Child Welfare League of America is pleased to provide this report of work undertaken to inform the development of a model for residential group care that reflects current research findings and the appropriate place of residential group services in the child welfare service continuum. The following activities were conducted during this initial phase of the project:

- Review of data on the utilization of residential group placements in child welfare
- A review of the literature on residential group care
- A survey of state child welfare agencies
- A survey of state child and family services provider associations
- A survey of California DSS, Children, Youth, & Families county offices

The findings of these activities are reported in sections II through IV of this document.

II. Utilization of Residential Group Care

Data obtained from CWLA's National Data Analysis System (NDAS) show that, as of 2005, 18.20% of the 487,409 children in out of home care were in either group home or institutional placements (NDAS, 2007). A total of 185,794 residential group care beds were available nationwide in 36,449 licensed facilities.

It has been known for some time that children in group care are older than those in the general child welfare population (Barth, 2002). In 2004, the average age of children in group care was 14 to 15 years compared with 10 to 11 years for all foster children. Group care placements are not, however, limited to older youth. In 2004, almost 5,000 (4,923) children under the age of six years were placed in either institutions or group homes. Of those, nearly 3,000 (2,988) were younger than three years old. Such placements of very young children are unevenly distributed geographically, with none recorded in some states and others having several hundred children younger than age six in group care. The length of these placements and the reasons for them are not known.

Male children are over-represented in the group care population. Data from 2000 through 2004 show that males have consistently comprised over 60% of the children in both group homes and institutions although they account for about 52% of all children in out-of-home care. African American children comprised about 35% of the total group residential care population, consistent with their representation in out-of-home care; however, Hispanic youngsters were slightly over-represented in institutional (not group

home) care, making up about 17% of the total out-of-home care population, but 20% of those in institutions.

Average lengths of stay in group homes range from 14 to 17 months, and in institutions from 13 to 15 months. Many children leave congregate settings after much shorter stays, however. Median lengths of stay in group homes increased slightly from 5.52 months in 2000 to 6.24 in 2004 and declined in institutions during the same period from 6.41 to 4.57 months.

Data from 2000 to 2004 show that almost 70% of children exiting group homes each year are reunified with their families. Reunification data for children leaving institutions is much more variable, ranging from a high of just over 80% in 2001 to 38% in 2004. It is still the largest single reason for discharge, however, with all others, including emancipation and moves to other placement settings, at well under 10%.

It should be noted that the above data show considerable variation from state to state. In some states, for example, different racial or ethnic groups are over-represented in congregate care; average lengths of stay in group care in 2004 ranged from a low of 1.7 to a high of 53.7 months and in institutions from 1.3 to 79.4 months.

A recent study of residential care in Illinois (Budde, et al., 2004) found several predictors of placement outcomes for youth: Repeated placement failures before entering residential care were associated with greater likelihood of a youngster's returning to a residential setting after having been discharged to foster care; gender was found to be significant in that boys were more likely to be placed in residential care; Hispanic youth were less likely to be placed residentially than other youth, while African Americans were more likely to be moved from group care to foster care but less likely to be discharged to permanency. Youth who experienced neglect in the form of inadequate supervision before entering out-of-home care were more likely to move from foster care residential placement, to move from one residential facility to another, and to be stepped back up to group care if discharged. Although they cannot be generalized to other locations, these findings may provide guidance for further study to identify variables related to the utilization of residential group care

III. Literature Review

A. Research in Residential Group Care

The utility and effectiveness of residential group care has long been debated among child welfare and mental health professionals and those concerned with the performance and accountability of human service systems. Some contend that all

group care is potentially harmful and that its use should be eliminated; others take the position that such placements are beneficial for some children in certain situations, and still others favor the wholesale use of group care as an alternative to the shortage of family placements or reliance on family placements that may expose children to further risk. Both positive and negative assertions about the effectiveness of residential care and its alternatives are often made without sufficient evidence (Jones & Landsverk, 2006; Knorth, Harder, Zandberg, & Kendrick, 2008).

This review of the literature focuses on the use of group care in the formal child welfare system. It summarizes what is currently known about the use of residential group care and the outcomes experienced by youth served in residential settings.

The limited study of the effectiveness of residential group care has yielded mixed findings. Some research has produced evidence of benefit for children (Knorth Annemiek, Zandberg, & Kendrick, 2008; Pecora, et al., 2000). On the other hand, concerns have been identified related to post-discharge maintenance of therapeutic effects and adverse consequences due to contagion of deviant behaviors among residents (Hoagwood, Burns, Kiser, Ringeison, & Schoenwald, 2001). Researchers have also questioned whether the costs are justified in view of some findings that indicate equal benefit from less intensive placements such as therapeutic foster care and family-based interventions in the community (Barth, 2002; Curtis, Alexander, & Lunghofer, 2001). Group care has been estimated to cost more than six times more than family foster care and two times as much as therapeutic foster care (Barth, 2002).

A review of research in 2000 led the U.S. Surgeon General to conclude that residential treatment had not shown substantial benefits to children and youth with mental health problems. That report also recognized the possibility of negative consequences because of deviant behavior spreading from one child to the next in group care. The report concluded that, for youth who manifest severe emotional or behavioral disorders, the positive evidence for home and community-based treatments contrasts sharply with the traditional forms of institutional care, which can have deleterious consequences (U.S. Public Health Service, 2000).

A more recent report strongly cautions against the group placement of youth with deviant behaviors, suggesting that, in such settings, antisocial behavior becomes the norm and a culture develops in which youngsters see it as a way to gain status among their peers (Dodge, Dishion, & Lansford, 2006). These researchers urge the use of family-based approaches based on behavioral principles as alternatives to group care.

The National Survey of Child and Adolescent Well-Being (2002) found that children in group care were four times as likely as those in foster care, and ten times as likely as those in kinship care to report that they do not like the people with whom they live.

They were also more likely to report never seeing their biological mother or father. Barth (2002) found that, as compared to children in foster care, re-entry rates of children in residential treatment were higher and that there were fewer aftercare services available to ease the transition home.

A central concern related to congregate care, whether in small group homes or large institutions is that care is provided by shifts of staff rather than by a consistent caregiver. This is of particular concern for infants and young children in view of studies that show poor outcomes associated with group care and general acceptance of the needs of these children for a relationship with a consistent caregiver (Barth, 2002; Harden, 2004). Barth, citing the work of Shealy (1995), further notes that, while it is theoretically possible for residential care staff to provide positive substitute parenting for troubled youngsters, the hiring practices and personnel supports in many facilities does not provide staff with the capacity to do this on a consistent basis.

A recent Illinois study found that over half of youth experienced negative outcomes from their first institutional residential care placement (Budde, Mayer, Zinn, Lippold,& Avrushin, et al., 2004). The researchers noted, however, that the requirement that a youth must have failed other placements to qualify for residential placement may preclude its planned use and negatively influence subsequent treatment efforts. The question of where residential group care belongs in the continuum of services for children has been posed by others as well. Finding answers to this question is difficult, however, in view of the great variability of residential care. Although widely considered the placement alternative of last resort, group settings are frequently used for reasons other than treatment, such as for emergency shelter care or simply because a family setting is not available or accessible (Barth, 2002; Pecora, Whittaker, Maluccio, & Barth, 2000).

Despite the large amount of negative findings and commentary related to residential group care, there is a body of research suggesting positive effects. A recent meta-analysis, for example, finds some support for the benefits of residential treatment (Knorth, et al., 2008). This analysis of 27 studies conducted between 1990 and 2005 indicated that residential settings that used behavioral approaches and included a focus on family involvement showed promising short term outcomes. Positive effects at one year follow-up were found primarily with cognitive-behavioral programs. The researchers noted that "specific training, aimed at social-cognitive and social-emotional skills of youths, can generate significant strengthening of treatment effect" (p.135). Studies consistently showed that youth with general and externalizing behaviors benefit more than those with internalizing behaviors. This analysis showed that only Multidimensional Treatment Foster Care was associated with greater progress in moderating problem behaviors than residential treatment.

Studies finding benefits of group care have consistently recognized the importance of the post-discharge environment in sustaining positive effects (Pecora, et al., 2000; Whittaker, 2001). Knecht and Hargrave (2002) note that positive outcomes are associated with the provision of aftercare; work with most families should extend over a significant period of time, only part of which involves residential care. This principle is further exemplified in findings from an outcome evaluation of the Boys and Girls Town program in which behavioral and well being gains on the part of participating youth were linked to the provision of post-discharge services (Bullard & Johnson, 2005).

Based on his review of research on the effectiveness of *psychiatric* programs for children, Ziegler (2007) notes that many of the negative stereotypes long associated with residential care are not supported by evidence. He finds an emerging recognition that the best systems of care should include alternatives that meet the individual needs of all children, some of whom will require placements of greater intensity for some period of time. Thus, he asserts, the central question should not be whether residential care is needed, but what its appropriate place is in a continuum of care.

The focus on outcomes rather than process in the limited research that has been conducted means that different types of residential group care and the essential components of each have not yet been clearly defined (Pecora, Whittaker, Maluccio, & Barth, 2000; Whittaker and Maluccio, 2002). Rigorous studies comparing outcomes for children in group care with children in family settings are also lacking, however (Barth, 2002; Jones & Landsverk, 2006). In general, research suffers from an absence of control conditions, poor description of program components (Knorth, et al, 2005), limited samples, failure to control for children's problems at intake, use of inappropriate outcome measures, and improper application by practitioners (Pecora, et al., 2000; Bullard & Johnson, 2005).

Although there is clearly a need for further research, studies conducted to date do provide some basis for identifying general programmatic features most commonly associated with better outcomes. These commonalities include high levels of family involvement, supervision and support from caring adults, a behavioral and skill building focus, service coordination, individualized treatment plans, positive peer influence, structure and discipline, academic support, community networks, comprehensive discharge planning, and aftercare (Barth, 2002; ; Curtis, Alexander, & Lunghofer, 2001; Knorth, et al, 2008; Pecora, Whittaker, Maluccio, & Barth, 2000; Whittaker, 2000).

In reviewing research regarding *psychiatric* residential services, Ziegler (2007) finds that to be most effective, such services "must be targeted, responsive, and individualized to the needs of the child and the family" (p.1). He further identifies five essential features that should characterize effective psychiatric residential services: (1) integrated into the overall system of care and including a continuum of step-up and step-down services

within the same provider organization; (2) providing a comprehensive, ecological, and integrated model of multi-modal treatment interventions; (3) committed to national standards of excellence and quality improvement and having an identifiable treatment philosophy and approach based on research and empirical evidence; (4) emphasizing the importance of the child's environment, including family interventions and partnering with families during and after residential care; and (5) impacting the child's positive thoughts and perceptions, emotional self-regulation, and pro-social skills and behaviors.

B. Promising Practices and Models

The promising practices described below do not account for all aspects of treatment; however, in limited research, they have been associated with positive findings.

Family-Centered Residential Treatment

Family-centered residential treatment may be reflected in more than one model. The two described here are Familyworks which was implemented at the Riveroak Center for Children in Sacramento, CA, and REPARE (Reasonable Efforts to Permanency through Adoption and Reunification Endeavors), a demonstration project conducted by Four Oaks of Cedar Rapids, Iowa, in collaboration with the Iowa Department of Human Services.

The Familyworks program achieved a decline in the average length of stay from 14 to 9 months from 1995 to 2000. Family-centered services were reflected in the following components: Staff-supported home visitation; family education; a parents' support group; structured family activities; parent advocacy; family therapy; inclusion of parents in daily activities and treatment milieu; and child/family team meetings (rather than treatment team meetings). A critical program feature for children referred by the child welfare agency was a "wrap-around" service that helped to identify and prepare family or alternative caregivers who would provide post-discharge placements (Knecht & Hargrave, 2002).

The REPARE model built on principles of family empowerment in efforts to maximize family involvement in the treatment and decision making process. It featured a strong focus on family relationships including connecting children to new permanency resources. The program also emphasized skills training, problem solving, and mutual goal development with families. A quasi-experimental evaluation in a sample of 139 children (82 in the REPARE group and 57 in a comparison group) showed that children in REPARE experienced shorter lengths of stay, were more likely to be discharged home (i.e., to a family setting intended to be permanent), and were more likely to be stable in their post-discharge placements at six months follow-up (Landsman, Groza, Tyler, & Malone, 2001).

The WAY (Work Appreciation for Youth) Program

WAY was developed at The Children's Village residential treatment program in New York. Its purpose is to improve the prognosis for youth in residential treatment by preparing them educationally and experientially for employment. The five core elements of the five-level model are *educational advocacy and tutoring*, *work experiences and work ethics training*, *group activities and workshops*, *financial incentives*, and *long-term, individualized counseling and mentoring*. WAY uses trained, paid mentors who commit to maintaining a relationship with the youth over the long-term, regardless of the challenges involved. A fifteen year longitudinal study found that most youth (76%) stayed in the program, gained work experience and saved money in a savings plan that was matched by the treatment facility. They also attended and completed school at rates higher than those for minority youth and youth in poverty in New York City (Baker, Olson, Mincer, 2000). Further information about WAY is available on line at http://www.childrensvillage.org/community-way2.htm

Residential Education

A preliminary study of a residential academy program which focused on education for older youth has shown some promise (Jones & Landsverk, 2006). Studies of 42 youth who completed the program showed a higher rate of high school graduation and college attendance and lower rates of homelessness and criminal justice involvement than have been reported in other research focused on former foster youth. The researchers note, however, that youth were selected for the program based on their ability to benefit from an educational setting and thus cannot be compared with those in other residential programs. Overall, the characteristics of residents were comparable to children in therapeutic foster care but not to others in residential treatment. Further information about the residential education program may be available from Loring Jones, Ph.D. at the San Diego State University School of Social Work.

The Sanctuary Model

The Sanctuary Model is described as a "trauma-informed whole system approach designed to facilitate the development of structures, processes, and behaviors on the part of staff, children and the community-as-a-whole that can counteract the biological, affective, cognitive, social, and existential wounds suffered by the children in care" (Bloom, 2005, p. 65). It was originally developed for adult survivors of childhood trauma and has recently been adapted for children in residential treatment. It rests on the premise that organizations can themselves become traumatized and traumatizing, unable to promote healing in the children they are charged to serve. The model strives to create an organizational culture characterized by *non-violence*, *emotional*

intelligence, *inquiry*, *shared learning*, *open communication*, *social responsibility*, and *growth and change*. The S.E.L.F. (*Safety, Emotional Management, Loss, Future*) framework provides a tool that helps to focus staff and clients on the tasks of healing. Evaluation is accomplished through measurement of indicators set by staff and client teams. More detailed information and training in the Sanctuary Model is available through the Sanctuary Leadership Development Institute at the Andrus Children's Center in Yonkers, New York.

IV. Survey Findings

Three surveys were conducted to identify jurisdictions which had, or were in the process of, developing innovations in the use of residential group care. One was a state survey, another was a survey of state provider agency associations, and the third was a survey of California counties. All surveys were administered through the use of Web-based Survey Monkey. Targeted participants were notified of the state survey through CWLA's electronic mailing list; notification of the provider survey was distributed through the National Organization of State Associations for Children, and California counties were informed using an email listing of county placement coordinators provided by the California Department of Social Services. The California survey was conducted in cooperation with Paper Boat Consulting which was working with that state to develop and implement a new approach to group care. Survey responses are detailed in documents included as Attachment A of this report.

A. State Survey

Twenty-six jurisdictions (18 states, the District of Columbia, Bermuda, and five Colorado counties) responded to the state survey. States responding were Arkansas, Connecticut, Delaware, Iowa, Kansas, Kentucky, Louisiana, Maine, Massachusetts, New Hampshire, New York, Ohio, Texas, Vermont, Washington, and West Virginia. Colorado counties were Arapahoe, LaPlata, Larimer, Rio Grande, and Teller.

Ten jurisdictions indicated that they had reduced their utilization or otherwise made substantial changes in their use of residential group care over the past three years. They included Bermuda, CT, DC, LA, MA, ME, NH, NY, NC, VT, and Arapahoe, Larimer, Rio Grande, and Teller counties. Reasons given for such reductions or changes are described below. The jurisdictions reporting each reason are shown in parentheses.

- Reduction in residential group care resulted from overall reduction in the number of children in foster care with no change in the distribution of placement types (NY);

- Reduction of residential placements by 58% achieved through concentrated efforts to find families for children (ME);
- Policy changes and/or utilization review to tighten gate-keeping on residential placements (Arapahoe County, CO; State of CO-reported by Rio Grande County; NH; VT);
- Increased use of community-based group homes as an alternative to residential treatment (MA; CT);
- Instituted family group conferencing (Larimer County, CO);
- Increased home and community based services including behavior management differential response and aftercare (Bermuda; LA; MA; Teller County, CO);
- Implemented Multidimensional Treatment Foster Care and emergency foster care (DC);
- Increased foster family recruitment (LA);
- Focused efforts to make family placements for children age 12 and younger (NC); and
- Greater efforts to place youth with kin (NH; VT)

While some jurisdictions reporting reductions in the use of residential treatment or other congregate care indicated that the changes had been accomplished primarily through the initiative of the public agency, several attributed them to public-private partnerships. Massachusetts, in particular, described a process in which community representatives and service providers were engaged in collaborative planning that led to redesign of some residential programs and movement of services that had been available only in residential care (e.g. behavior management) to the community. North Carolina also indicated that some residential providers had begun to develop foster family homes. Teller County, Colorado's response described collaboration that included mental health, youth corrections, Medicaid, TANF, local schools, the courts, local non-profits and families that had led to a 50% reduction of residential placements.

Arkansas, Delaware, Iowa, Kansas, Kentucky, Ohio, Texas, Washington, West Virginia, and LaPlata and Park counties in Colorado all indicated that they had not made recent significant changes in the utilization of residential group care. In some instances, this was because of barriers or because innovations that were underway had not yet been fully implemented; in others, it was because the jurisdiction had already implemented measures to achieve better utilization of residential services. The following are notable responses received from these jurisdictions:
- Arkansas is beginning a system of care initiative intended to ensure that children are placed in the most appropriate setting.
- Delaware has added beds to increase residential capacity for hard to place older youth.

- Iowa is moving to performance-based contracting for all services, with the addition of group care to be the final phase of the implementation.
- Kansas requires in its contracting that providers of foster care services keep group and residential care at less than 10% of the total census. The state also supports the use of cognitive behavioral approaches in residential treatment.
- Kentucky indicated a need to recruit more foster families for teens.
- Park County, Colorado uses intensive family services to keep children at home whenever possible; residential placement is used when it is determined to be the only reasonable option.
- Texas described being in the early stages of developing a procurement process and level of care system that is intended to better ensure appropriate placement decision making. Geographic distribution of placements is a great challenge because of the size of the state, and the tendency of providers to concentrate in major urban centers, leaving rural areas without sufficient resources.
- Washington implemented performance based contracting that includes outcomes related to permanence and placement stability. Additionally, the state has established evidence-based models including Multidimensional Treatment Foster Care and Aggression Replacement Training that strive to keep children in community-based placements. The use of the Children's Functional Assessment Rating Scale also helps ensure accurate decision making on behalf of children.
- West Virginia described the work of the state Foster Family Treatment Association, Shelter Care Network, and Child Care Association in striving to improve programming and outcomes. The Behavioral Health Commission and Commission to Study Residential Placement of Children include broad based membership of professionals, families, and community leaders. Two recently implemented initiatives targeting placement services are the WV Service Array Process and WV System of Care.

Respondents cited funding shortages, regulations, provider resistance or poor relationships with providers, difficulty in building consensus, lack of cooperation of judges and line staff, and lack of staff time as key factors limiting implementation of plans to improve placement services. Several, however, reported that they had successfully engaged both communities and service providers through a lengthy but rewarding collaborative process that allowed all parties a voice in decision making.

B. State Association for Children Survey

Despite follow-up reminders and extending the survey time, only nine responses were received from state associations. Responding associations included the Alabama Association of Child Care Agencies; Colorado Association of Family and Children's

Agencies; Indiana IARCCA; Coalition for Family and Children's Services in Iowa; Kentucky Children's Alliance; Ohio Association of Child Caring Agencies; Minnesota Council of Child Caring Agencies; New Jersey Alliance for Children, Youth, and Families; and North Carolina Children and Family Services Association.

Five respondents indicated that changes had been made in the utilization of residential group care in their states. Alabama and Colorado cited specific declines of 30% and 40% respectively in the use of group care. Some responses indicated that changes in group care utilization appeared to be driven solely by the desire to save money; others expressed concurrence with public agency emphasis on placing more children with relatives, providing community based services as alternatives to removal, and expanding family placements.

Funding was cited as a major barrier by most respondents, especially when expressed in static rates for provider services. When payment does not keep pace with provider costs, quality of care suffers and is reflected in placement instability and greater length of stay at high levels of care. Lack of adequate funding was also cited as thwarting private sector support in expanding the service array into non-residential services.

Overall, state association respondents reported little real public-private partnership. Several indicated that public agencies controlled the direction of resource development and funding without significant input from providers.

C. California County Survey

Although reminders were sent and the survey time was extended, only nine counties responded. These were Mendicino, Orange, Placer, Riverside, San Diego, Santa Barbara, Santa Clara, and Sutter.

Eight of the nine respondents indicated that there had been substantial changes in the utilization of residential services in their counties over the past three years. In the lone county not reporting changes (San Diego), Multidimensional Treatment Foster Care and wraparound services had already been implemented.

Counties reporting reductions in the use of group care attributed them to either new procedures, additional resources, or both. Notable findings among the responses included the following:
- Some counties had established new procedures that allow for better gate keeping of residential services and more timely decision making for children who are placed residentially.

- Sutter County reported having a "residential team", consisting of a case manager and a therapist, who provide oversight of placements and linkages with the child's family. The county also holds regular interagency placement review meetings to assure more timely movement to permanence.
- Santa Clara County is doing "family finding" for children in residential group care, linking them to relatives. They reported moving 35 of 50 children to lower levels of care within three months.
- More counties attributed placement reductions to additional resources. Several referenced state legislation (CA SB163) that had made funds available for additional service supports such as wraparound, family preservation, or treatment foster care.
    - In Orange County, the use of wraparound services, a contracted family finding program, Multidimensional Treatment Foster Care, and relative resources reportedly led to a drop in children served in residential services from 800 in 2000 to 150 in 2007.
    - More rural Mendocino County estimates that the use of wraparound services has prevented the placement of approximately 35 youth.

In most counties, innovations had been achieved through the collaboration of multiple county-based public agencies. Orange and Kern counties, however, reported public-private partnerships. Orange County described county collaboration involving public agencies as well as contracted private service providers and supported by the county administration.

V. Toward a Model for Residential Group Care Use and Transition

Residential group care is viewed negatively by many child welfare professionals. Although research findings are mixed, there is a notable lack of rigorous research that supports the benefits of residential treatment over evidence-based family centered services and less restrictive out-of-home care settings such as treatment foster care. It should be noted, however, that much research examining residential group care in child welfare has been conducted using placements made in accordance with questionable practices and procedures and in facilities that are under-resourced and/or have not implemented evidence-based treatment approaches. Thus it becomes difficult—perhaps impossible—to sort out whether the failure of residential group care to show greater benefits is to be attributed to the service itself, the measures by which its success has been assessed, or the way in which it has been applied.

It is clear from the literature that residential group care in child welfare is not one, but many things. There are emergency shelters, long term programs, short term programs,

and programs that use a variety of therapeutic approaches or no defined approach at all beyond providing twenty-four hour supervision and poorly defined "milieu therapy".

The lack of clearly defined types and key features of residential care means that there are also no empirically derived criteria for determining whether residential placement, rather than family-based care, is best for a particular child. This allows for great variability in the application of residential treatment.

In spite of the gaps in knowledge, sufficient information exists to at least begin the delineation of a framework for more effective placement decision making and application of residential group care. Most solidly, research in residential group care and related fields suggests that, for most children, and especially for the youngest, family settings are optimal. It is thus implied that residential group care should be used sparingly and with specific purpose. The summarized research and the experiences of agencies responding to the surveys administered in this project suggest the inter-related guidelines described below:

➢ **Specificity of purpose.** Agencies and residential providers must work together to clearly define program capacities and establish placement criteria that connect the services offered to the assessed needs of individual youth. Consistent gate keeping and monitoring processes can ensure appropriateness of placements and timely movement of children to more family-like settings. The targeted use of residential group care may mean that it is best used, not after all other placements have failed, but to achieve treatment goals that can facilitate a child's trajectory to stability and permanence. Gate keeping procedures should include a feedback loop so that decision makers are aware of the outcomes of their decisions both for individual youth and in aggregate form. Policies and gate keeping processes that reflect the most current research and local evaluation findings about the application of group care can best guard against its indiscriminant use based on convenience or political pressure.

➢ **Integrated service continuum.** In child welfare systems that are over worked and under resourced children are likely to be placed in residential group care for reasons that have more to do with custom and availability than with their individual needs. And in child welfare systems, perhaps more than in mental health, children who experience residential placement often lack the family or known family-like connections needed to readily implement evidence-based, family centered alternatives to residential care, at least at the time when placement decisions tend to be made. This means that, unless an array of resources is available, children will almost certainly be placed in residential care inappropriately. A continuum of placement resources must include, at a minimum, geographically distributed emergency family foster homes, treatment

foster care, and clinical services to support foster, kin, and birth parents in managing behaviors, rebuilding relationships, and maintaining stability.

➢ **Targeted resource development.** Good placement decisions are not driven by happenstance resource availability. Public agencies and providers must engage in needs-based resource development based on shared data. Good providers offering services that are not needed or clearly beneficial to youth should be encouraged and supported in redesign. An "if we build it they will come" mentality may serve some providers and political interests, but it cannot be ensured to serve children.

➢ **Strict adherence to quality control and improvement.** Uniform data collection and ongoing process and outcome evaluation must be developed and supported collaboratively between public agencies and contracted residential services providers. Studies that show benefits of residential group care do so for high quality, well-structured, behavioral, and goal oriented services.

➢ **Family involvement.** Multiple barriers exist to family involvement with children placed residentially through child welfare systems. First, as Pecora and his colleagues (2000) point out, studies of children entering residential care show that a high percentage come from families facing a constellation of problems. Geographic proximity is also another prevalent factor impeding family involvement with youth in residential group care as such facilities are often centered in urban areas rather than being distributed throughout jurisdictions. And even when public agencies and private providers have a philosophical commitment to family involvement, they may lack the skills and resources to engage families. Most particularly, ensuring family involvement requires attention to:

  ▪ **Geographic proximity and accessibility of placements.** Agencies and providers must work along with communities to achieve better distribution of placement resources. Where actual placement proximity cannot be achieved, there must be commitment to conducting outreach through outplacement of therapists or contracting with locally based therapists to be part of the treatment team and form linkages with families. Supports for visits such as transportation, and flexibility in scheduling, and use of technology to facilitate family inclusion in planning and treatment can also promote involvement.

  ▪ **Finding families.** Many children have lost connection with their families and have no strong positive adult relationships at the time they enter residential

group care. For these youngsters, concentrated efforts to identify family or other adult resources are essential. Both of the family-centered residential group care programs featured in the *Promising Practices* section of this report included a strong focus on connecting children to adults who could either be a placement resource or, at least, play a significant role in their lives. The family finding activities reported in section IV by some of the California counties also provide evidence that it is possible to establish such relationships for many children and that doing so can provide a path to permanence. Such efforts are ideally built on public-private partnership. If public agency staff does the primary work in finding and engaging family or fictive kin, residential group care staff must also reach out to involve them in the child's treatment and discharge planning. If, on the other hand, residential providers are expected to perform the family finding activities, they must be provided with the necessary information and funds. As Knecht & Hargrave (2002) note when discussing this issue "The detective work involved with locating kinship resources or other connected people is intense and cannot be left be left to the old 'discharge planning' mode"(p.33).

- **Building a family-centered philosophy.** Productive family involvement means that family strengths must be identified and supported, that children and families must be fully included in placement and treatment planning decisions, and that the participation of parents and other family is encouraged in the day-to-day life of children in residential group care. Such family work requires additional time and skill, and perhaps a change in organizational culture, for many residential providers.

- **Discharge planning and individualized aftercare.** Effective discharge planning begins at the point of placement in residential group care. Data show that many youth improve while in residential treatment but that gains are often lost when they leave. Establishing specificity of purpose for residential group care and building an integrated service continuum as described above, are necessary conditions for realistic discharge planning and provide the post-discharge needed by youth and their caregivers. Such planning and a commitment to aftercare also require policies and resource that provide the level of service intensity and duration needed to maintain youth in community settings.

VI. Looking Ahead

The information gained through the surveys and literature and data reviews conducted during this initial phase of work to develop a model for the transition of residential group care provides direction for the development and testing of a working model. That next

phase would necessarily be undertaken in cooperation with public and private agency providers, such as those responding to the surveys, who have begun implementation of at least some of the guideline elements described in section V and are committed to finding and supporting a continuum of placement resources that best meets the needs of the children and families they serve.

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